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“I Also Have to Live Here”: Ethics of Neighborly Intimacy among Community Health Activists in Delhi

Abstract

What makes community health activism and ethical undertaking/? I examine how among Accredited Social Health Activists (ASHAs) in an urban poor neighborhood in Delhi, health work is underscored by relational sensibilities. By primarily situating the inquiry into their everyday lives, and beyond the trajectories of their work, I show how care work and relational commitments among ASHAs exceed the forms of care foregrounding in the public health program protocols. ASHAs operate through *ethics of neighborly intimacy* – relational knowledge and acts, guided by ethical obligations towards their neighbors, and underscored by the existing dependencies, care, detachments, and differentiation of relationships.

Keywords: community health workers, care, ethics, India, neighborly relations, urban poor

Having spent her morning at the primary healthcare center, Manju has just come back to Halpuri, a *jhuggī jhompri* (an auto-constructed urban poor settlement) where she lives. Being an ASHA – (Accredited Social Health Activist) – she will continue her work from home, among her neighbors.¹ But it is not easy, she says, especially when it comes to *motivation*. “If people are fighting, or are busy because there has just been a delivery [of a newborn] at home, how [...] will I *motivate* them? I also have to live here [*mujhe yahīm rahnā padtā hī hai*]. Speaking of the difficulties in approaching women after deliveries and motivating them to show up at a governmental clinic for check-ups, Manju expressed the importance of the “living here” with an emphatic Hindi particle *hī*. Doing ASHA work successfully, without damaging her relations with neighbors, required a regard for them: to attend to their needs, and to know their hardships, such as ongoing familial quarrels.

Working for the National Health Mission (NHM) of the Indian Government targeting urban and rural poor in India, a program which primarily focuses on maternal and children’s health, ASHAs are trained to *motivate* (*samajh denā*) their neighbors so as to alter their health behaviors, and to facilitate their access to public healthcare. The public health discourse designates ASHAs as “agents of change” and mediators between their communities and the governmental clinic (GOI 2005). ASHAs extend developmental and medical knowledge and norms into the everyday lives of the poor. They are designated as caring figures, close to their communities, able to act indiscriminately because of their close connections.

ASHAs’ intimate relational commitments and forms of care, however, exceeded the boundaries of categories and socialties imagined within the public health discourse. While ASHAs’ memberships in their communities were seen, from the perspective of the health program, as facilitating the access, for ASHAs in Halpuri, being a neighbor and a governmental worker were not always compatible. This conflict of commitments –

commitments to the health program and to neighbors, which animated ASHAs' dual roles, is the central theme of this article. ASHAs' work was underscored by what I term *ethics of neighborly intimacy* – relational knowledge and ways of acting that underlined everyday life in Halpuri, where residents live literally side-by-side, and where neighbors witness and take part in each other's intimate lives. Throughout my fieldwork, ASHAs often suspended and altered their work of motivating their neighbors explicitly about the "right" kind of healthcare. Enfolding their work in negotiations of neighborly intimacy allowed ASHAs to avoid potential conflicts, enact their caring roles and to sustain their lives livable in the face of vulnerabilities posed by poverty and everyday life in an urban poor settlement.

Anthropologists noted the ambivalence of the Community Health Workers (CHWs) who are both carers and salary recipients, positioned between the state and communities. Straddling the roles of a worker and a compassionate neighbor, they operate a "double medical citizenship" (Nading 2013). CHWs may perceive their work as an apparent economic opportunity, a chance for self-realization, care for their communities, and empowerment (Bhatia 2014; Gjøstein 2014; Maes 2015; Swartz 2013). Actors similar to CHWs reproduce yet resist the developmental state (Gupta 2001, 2012; Pinto 2008). Yet, the CHW work may surpass strict governmental health protocols and generate alternate connections with landscapes and non-humans (Nading 2012). However, neighborly relations in everyday lives of the CHWs and modes of belonging in the communities where they work have remained largely unexplored.

Viewing ASHAs' subjectivities as inculcated within the larger context of their everyday lives, their entanglement in multiple relationships and commitments that exceed the prescribed health activist roles, I explore ethical dimensions of their neighborly relations. More than just by community health concerns, ASHAs' role was also underscored by care as a moral, relational project (Garcia 2010; Kleinman 2009). As illuminated in Manju's

reflection that she *also lives* in the neighborhood, community health work depends on these women's "moral striving" in everyday life (Pandian and Ali 2011; Das 2012; Zigon and Throop 2014). This moral striving is organized by "ordinary ethics", - ethics that emerged in the realm of the everyday, in language and practice (Das 2012; Lambek 2010).² In Lambek's words, ordinary ethics are "grounded in agreement, rather than rule, in practice rather than knowledge or belief, and happening without calling undue attention to itself" (Lambek 2010:2). Ordinary ethics allows to attend "ethical dimension of everyday life in which we are not aspiring to escape the ordinary but rather to descend into it as a way of becoming moral subjects." (Das 2012: 134). In their daily lives, ASHAs exercised judgement, and discerned "when to follow one's commitments and when to depart from them, or how to evaluate competing and incommensurable commitments" (Lambek 2010:28). Ethics of neighborly intimacy that organized the ASHAs' moral becoming was underscored by subtle acts of attending and regard to the others in day-to-day practice. Yet, central to the neighborly ethics in Halpuri were not so much efforts to maintain closeness but, more strikingly, acts creating distance and detachment from the neighbors they lived so closely with (Han 2014; Neumark 2017). Furthermore, the ASHAs' relatedness to the communities was differentiated: while they belonged to and depended on their neighborhood as a whole, they cultivated friendships with concrete others. As we shall see, ethical dimensions of ASHA work manifested through the suspension of "motivation", concealment, by means of not saying, and explicit care for those close to them.

Critical understanding of ethics of community and neighborly relations among CHWs is crucial because across the world, women are mobilized precisely because of their gendered capacities for care, embeddedness in the communities and thick social relations that are seen as assets potentially mobilizable for the public health ends. The National Health Mission (NHM) of the Indian Government was initially launched to facilitate horizontal health

delivery in India, and improve child and maternal health. ASHAs were introduced as one of the program's innovative elements that would enhance community participation. However, in Halpuri, residents and functionaries predominantly saw the ASHA program run by the local Primary Healthcare Centre (PHC) as a governmental health intervention, preoccupied with family planning. Thus, ASHA's unique positioning as both neighbors and governmental activists allows an exploration of how relational commitments are interjected with state power and governmental interventions underscored by morally inflicted judgments about right and wrong bodies and care practices.

Following relational ethical imperatives resulted in ASHA work deviations from the program protocols. Yet, these were not failures of care. Where medicine, illness, and care are constituted through intimacies, relationships, and commitments (Das 2015; Gammeltoft 2014; Han 2014; Pinto 2014; Venkat 2017), such deviations from the program suggested that care exceeds what medicine prescribes. For ASHAs, moral striving and care involved both, doing health work, attending its effects on neighborly relations, and efforts to make life with others livable. In the context where the program's gains were questioned and where public health boiled down to achieving targets of family planning, ASHAs thrust the ethical project in their work.

Methodologically, I situate ASHAs' work and subjectivities beyond the governmental clinic and the program, and in the larger context of their residence in Halpuri, where I have conducted nine months of ethnographic fieldwork exploring health-seeking practices and medical ecologies among the urban poor between 2012 and 2013, and have been returning to the field since then. Initially, I established contacts with the residents in the neighborhood rather than the governmental program or a clinic, which enabled an exploration of the ASHA work beyond the formal trajectories dictated by the program, and generated insights into the indeterminate temporalities of the ASHAs' daily lives as neighbors. Instead of assuming

ASHAs' relations with their communities as pre-defined, underlined by attachments and the mutual acceptance of the program gains, an assumption underscoring the ASHA program, I examine how relations and intimacies are dynamic, differentiated, and indeterminate. Thus, this article also makes a methodological case for studying a phenomenon in practice and by "being there" (Aulino 2016; Borneman and Hammoudi 2009) as it ethnographically follows ASHAs' daily lives over a prolonged period of time.

COMMUNITY PARTICIPATION AND GENDERED POLITICS OF PUBLIC HEALTH

The Indian Government launched the NHM in 2005 as an effort to achieve the Millennium Development Goals, particularly in the fields of maternal health and child mortality, and to launch horizontal and integrated approach to public healthcare through mobilization of CHWs, setting up of PHCs, and introducing community participation. The ASHA program is an innovative element of the NHM resulting from the recent revival of mobilization of CHWs across the Global South that resurged since the Alma Ata Declaration (UNICEF et al. 1978). It harks back to various colonial and post-independence public health and NGO-driven initiatives mobilizing CHWs (Bhatia 2014; George and Joshi 2012; Lehman and Sanders 2007; Van Hollen 2003). Yet, the program also marks a neoliberal shift towards community empowerment and participation in India's development, as the CHWs enable a cost-effective health service transfer to communities themselves (Sharma 2008; WHO 2008). The involvement of community and civil society in the NHM is intended to mark a shift in India's public healthcare delivery that had traditionally been state-led and dominated (Donegan 2011; Unnithan and Heitmeyer 2014, 2012). However, the collaborations between civil society groups, NGOs and the state not only opened a discursive space for activists' rights-based agendas, and sought to diffuse state's dominance through innovations such as

community monitoring, but also re-affirmed the state as the main public healthcare provider (Unnithan and Heitmeyer 2012).

The intended “shift” towards less significant role of the state in India’s public healthcare delivery, ascribed to the program due to its community participation element, is therefore not unambivalent. As Mishra (2014) argues, the statistical and hierarchical approach to the reporting of achievements to the higher levels of state bureaucracy subverted the program’s ideological focus on community participation. In Halpuri, ASHAs were accountable to auxiliary nurse-midwives, who worked under the supervision of the PHC doctors. The PHC, ASHAs and Midwives took records and produced bureaucratic evidence of their work results, such as numbers of children vaccinated, contraception and sterilization uptakes, and institutionalized deliveries. ASHAs’ knowledge about their neighbors and the reasons for low institutional delivery uptake, for instance, was eluded in the system that relied on the numbers evidenced in their diaries. Less than activists – a role that was vaguely defined in the program from the outset (Saprii et al. 2015) – ASHAs were seen and saw themselves as governmental workers. In Halpuri, but also generally in the popular parlance, ASHAs were referred to as “ASHA workers”, rather than “activists”.

Furthermore, the NHM functioned differently in Delhi, the first city to launch the program that had initially been designed for rural areas. For instance, there were no panchayats (village councils) in Delhi, and, the program functioned within the existing urban healthcare ecology, targeting only what it designated as “vulnerable” and “high risk” areas such as *jhuggi jhompri* and resettlement areas, and urban villages. Throughout my fieldwork I have observed how reproductive and children’s health and family planning took up the largest portion of the clinic’s and ASHAs’ work, marking a continuance in India’s public health preoccupation with these issues, and constituting gendered healthcare provision. In Halpuri, the clinic itself was known as “women’s clinic” – hinting to its focus on

reproductive health issues, rather than primary health or non-communicable diseases, which were mostly entrusted to unlicensed biomedical practitioners in the area.

In this context, ASHAs were mandated as governmental public health representatives, incorporated into the Delhi's health ecologies and bureaucratic health apparatus preoccupied with the reproductive health of the urban poor women. This had implications to the ways in which the intended community participation was refracted through everyday relationships in the area. As Donegan (2011) noted, the program's activities did not engage, but rather "constructed" community through collaboration of diverse actors on diverse levels. I suggest that such community construction and politics took place not only through discursive and institutional organization, but also through the negotiations of neighborly intimacy and in most ordinary contexts. While ASHAs' specific caring roles were mandated by the affiliation with the state, they navigated between belongings to the program and their neighborhood. Their gendered care work exceeded the ways the program imagined community care and participation and was refracted as a moral project, embedded in everyday intimacies, friendships, inequalities and belongings.

ETHICS OF NEIGHBORLY INTIMACY IN HALPURI

Halpuri is an auto-constructed poor settlement (*jhuggī jhompri*) located in an urbanizing village at the margins of Delhi. Most of its residents are daily-wage laborers who live in large households and have incomes below the poverty line. The imperatives of neighborly intimacy were palpable in the materiality of Halpuri. Here, the houses shared thin, fissured walls, and tight clustering shaped the narrow *galīs*, where clay cooking stoves were constructed, and where many "domestic" activities took place. Women cooked, washed the dishes and clothes, and relaxed in each other's presence in these seemingly semi-public spaces. During my fieldwork, I observed such daily intimacy while spending lot of time near the home of Anita,

one of the ASHA workers. Next to Anita lived Shalini with her mother Meena, two sons, a daughter-in-law, two grandchildren, and a husband. The third household was Sanjana's, who lived with her four young and unmarried children, one married son and his wife, and a grandchild. Finally, in the *jhuggī* (hut) next door lived Sanjana's married daughter Ruby with her husband and three, later four, small children. Few men who stayed there worked during the days. Roofed with plastic and construction scrap materials, the *jhuggīs* were low-slung here, and the houses formed an enfolded neighbors' cluster on the fringe of Halpuri, and strangers would rarely pass by. In the afternoons, after finishing their morning chores, women all sat to rest next to each other on the thresholds of their huts, while children played in the narrow *galī*.

Much of daily domestic and household activities in Halpuri were not only exposed to the public gaze, they also had to accommodate the needs of lives of those who lived next door. Yet, boundaries between the public and intimate, or a family and a household were not absent (cf Datta 2016; Kaviraj 1997). Instead, they were negotiated and produced through everyday acts, underlined by relational ethics. Intimacy and relational dependencies were underscored by both neighborly care and the modes of detachment and distancing.

Under conditions of dire poverty or amidst incidents and anticipations of violence, communities whose members strongly depend on each other maintain neighborly relations less through direct and explicit acts of care, bonding and displays of intimacy, but through small acts of "maintaining 'the face' of the other" (Das 2012), hidden inexplicit favors (Han 2014), or detachments (Neumark 2017). Such ethical regard for others and "care for relationships", as Neumark (2017) shows, may also take the shape of detachment, directed at efforts to sustain already precarious relationships. In South Asia, the politics of neighborliness is constituted by "co-presence of conflict and habitation" (Singh 2013), and

neighborly relations gone awry can bear dire consequences on the possibilities of life itself (Chatterji and Mehta 2007; Das 2007; Datta 2016).

Similar modes of detachment and distancing to make life livable and accommodate relations also animated ethics of neighborly intimacy in Halpuri. In their descriptions of everyday in the neighborhood, many residents told how in their daily lives they avoided conflicts and tried not to get involved in the fights that were pervasive in the area. Daily undertakings had to be agreeable among neighbors if one wanted to avoid spoiling relations. If disregarded, the risk of escalating quarrels was high. Quarrels often broke out over loud music or TV, queues at the water taps, open sewage construction work impeding paths, or because of children's misbehavior. The daily arduous task of fetching the water from the public taps would often risk ending up in skirmishes among women, and many avoided such fights and maintained a distance from their neighbors. Quarrelling was frequent, and women often told me that life in Halpuri was exhausting because of such conflicts (see also Das 2012; Snell-Rood 2015). It was also known that the stakes of such quarrels were high. For instance, filing legal cases which would result in a family coming under police's harassment was not unheard of.

These eschewals were not impulses of estrangement. Avoiding the neighbors in Halpuri was barely possible. Living in Halpuri demanded a cultivation of ethics of neighborly intimacy through regard of the others in the most mundane endeavors. Underlying both, disagreements or peaceful relations, was mutual recognition of the extent to which one can violate the sphere of another family not only in terms of spatial micro-politics, but also by interfering in their affairs, challenging another family's or person's respectability.

A HOPE, AN ACTIVIST, AND A NEIGHBOR

As ASHA, you shall do your best to help your own people in their struggle for health and share joys of life. People have expectations from you.

(Government of India 2011)

As the above quote from an ASHA training manual articulates, ASHAs are the cornerstones of the community health approach, and main “agents of change”. Key to the ASHA program is their belonging to communities and the assumption that women cultivate close and caring relations with their neighbors, and invigoration of such caring relations by projecting ASHAs as intermediaries with a mission of hope. Their title – *āśā* (hope) suggests they are expected to improve the wellbeing of “their own” people who are hopeful for development and improved health. This role of ASHAs compelled them to “see as a state” and “as a neighbor” simultaneously (Nading 2013). Monetary incentives served to sustain ASHAs’ identities as governmental affiliates and to acknowledge urban poor women’s labor while at the same time paying only for work considered as completed.³

ASHAs’ twofold role in Halpuri was epitomized by *samajh denā* (to provide an understanding, to motivate) – the task of transforming neighbors’ beliefs through verbal and practical strategies of persuasion, motivation, and facilitating access to healthcare. *Samajh denā* relied on blurred boundaries between ASHAs’ work and residence in the neighborhood and harnessed their everyday relations for advancing the protocols of public health. Formally, the program mandated ASHAs with a number of tasks ranging from keeping track of and referring pregnant women or newborn babies to the neighbourhood’s PHC, facilitating institutional deliveries and sterilization operations, and making sure children received the required vaccinations. ASHAs documented their activities in worksheets of ASHA diaries, materializing their state-like gaze. Each month, new pregnancies were to be noticed, newborns identified, and women’s bodies sterilized. Two columns indicated what was the

central ethos that underscored ASHAs' work: "expected" and "achieved", hinting at the lingering target approach in India's reproductive health programs (see Van Hollen 2003). I would often find Anita at home, filling in her diary while also attending her children and cooking, or sitting in her *galī* along with her neighbors. Writing was a rarely seen activity in Halpuri, and ASHAs prided themselves in being literate and versed in bureaucratic paper work.

ASHA tasks were intertwined with each other and with ASHAs' cultivation of existing neighborly relations, and expansion of their social circles. I often accompanied Anita and Manju on polio-vaccination rounds, during which they visited residents of surrounding areas from door to door. During one of such outreaches in Anita's working area, we walked slowly along the *galīs*, following the WHO training guidelines not to miss the *jhuggīs* in the messy and unplanned areas. This area, Manju noted, is easier to dispense polio drops than Halpuri: the lines are straighter, and one risks less to miss a child. ASHAs encouraged residents to vaccinate their children, and marked each vaccinated child's nail with a marker. They often had to reassure parents the vaccine is beneficial. In some areas, they noted, parents were more hesitant, and disliked that children would often get fever after being vaccinated; refused to wake children up if they were sleeping, or told ASHAs to find children if they were playing further from home. Anita knew women's names, their reproductive health statuses, numbers of children, and often stopped to talk to them about other health issues: "Now, we should be only doing the polio work (*polio kā kām*), but as we are walking around, we end up doing other tasks too" - Manju said. After finishing, she headed back to Halpuri to meet a woman who wanted to have a copper-tee insertion since she had four daughters.

Not always, however, ASHAs knew areas and neighbors well. Sometimes, they found new residents who rented a house from the previous ones, or could not follow up on the previous cases because people had moved elsewhere. ASHA's connections also depended on

community divisions, belongings, religious, caste and ethnic hierarchies within Halpuri, as they were less familiar with persons who lived further from them, or with whom they did not interact on the daily basis. On one of the polio vaccination outreaches with Anita, we entered a secluded garbage sorting cluster, inhabited by Muslim migrants from Bengal. Anita commented how shocked she was by the living conditions of the area that lied just a few hundred meters from her own house. Struggling to communicate as the residents spoke only Bengali, she and Anganwadi helper dispensed polio drops to the children, playing on piles of garbage. As one woman refused to vaccinate her child, Anita asked a passer-by to help to translate, and tried to persuade her the vaccine will do no harm. The woman then changed her argument and stated the child is ill, and therefore cannot take the vaccine. In response, Anita stated that the child runs around and does not look seriously ill, and therefore should take the vaccine, to which the woman conceded.

ASHAs were mediators between the residents and the health workers also at the PHC. Often crowded with queuing women, PHC was a noisy place, where women's chitchats mingled with the health worker's shouts to each other and the patients. Antenatal check-ups were conducted every month, during which women's medical records were updated, blood samples taken, and iron tablets distributed. Mediation often took place if a woman was a relatively recent bride migrant to the area, illiterate or shy to talk to the governmental health workers: "2 children were lost (*kharāb ho gaya*)", a midwife noted while writing down a woman's medical records, "total is 6." She then called a responsible ASHA – Geeta - to help to identify a woman's address. Geeta began to describe the house and the lane: "it's next to the pit of garbage [...]" "Should I write in the journal she lives next to a pit of garbage?" [turning to the woman] Is there someone here with you? Bring your husband next time". Such interactions were common at the PHC, and ASHAs were called to step in on various occasions.

Samajh denā positioned ASHAs not only as health activists, but also as actors who had to exercise a judgment about their neighbors. ASHAs working in Halpuri often emphasized it was a “high risk” area, with different health problems than those in the villages, where health problems were “normal”. “High risk” also had moral undertones, directed towards specific individuals. Seeing small children roaming around alone in a *galī* as she was dispensing polio vaccine, Geeta expressed dissatisfaction how uncared and dirty they were: “Their parents take all the water they can from the taps – but still, their children remain unwashed”. Geeta referred to the constant quarrels about water in Halpuri, and the neighbors who took unfairly more water than others in an area where it was scarce. Similarly, Anita made judgments about the failures and consequences of neighbours’ non-compliance with the health norms she advocated. One day I found her concerned, and she told me she had been visiting and consoling a family who had lost their first child. The mother-in-law, Anita said, was of “old thinking” (*purāne khayalat kī*) and had given dirty water to the baby.

Training activities, diaries, ASHA tasks, and acquired understanding (*samajh*) granted ASHAs legitimacy and facilitated the ways in which they saw themselves and their neighbors. All ASHAs I met strongly believed in the health and childcare norms they worked with, and took pride in their ASHA activities. Being mostly preoccupied with family planning, reproductive and child health, ASHA work was underscored by the differentiation between bodies, bad and good, backward and modern, disavowed and desirable, commonly upheld by reproductive healthcare programs (Ginsburg and Rapp 1995). “Old knowledge” (*purāni samajh*) marked the bodies that contrasted to the bodies underscored by modernizing and medicalized knowledge. In this light, ASHAs could be thought of as agents of development and medicalization, whose subjectivities were transformed through governmental interventions and trainings into the rationalized selves that sought to impart moral and medicalized norms on to their communities, which in turn was presented as

backward in the public health discourse. However, whereas ASHAs' formal activities driven by their *samajh* were clearly defined in manuals and the program, the ethical sensibilities of their relationships with neighbors and communities and care exceeded these formalized roles.

THE LIMITS OF *SAMAJH DENĀ*

Like Manju, who expressed the difficulties in motivating neighbors on a daily basis, Anita talked about the troubles when visiting women before or immediately after childbirth, collecting required medical forms and *motivating* her neighbors. "Madam [doctor] is asking for documents to be delivered quickly. I can't do it when people have problems. How will I live here, If I get into a conflict with my neighbors? If I fight with them, they will never listen to me". Asking for forms or gathering information from a family required consideration of a family's existing situation that Anita, a resident of Halpuri, knew well. Halpuri was also her living place, where the people she was supposed to "motivate" were the ones she had to live with on a daily basis. Anita's observation also reveals her own emphasis on her knowledge of the community: the denial of it, which potentially results in conflicts, would impede not only her daily life, but also her ASHA work.

Failing to maneuver these vagaries would often result in pay-cuts for ASHAs. When they avoided pressurizing their neighbors to undergo bureaucratic procedures, ASHAs risked losing their incentives. "Every month I went and took rounds around their home and wasted my time [*time waste kiyā*] and then I haven't earned anything [...] so what is the use [*fāydā*] [of such work] for us?". Manju reflected on how her pay was cut when, after visiting and attending a family all month, she was not able to complete required forms since the family was going through many troubles and did not have time to respond.

In their daily lives, ASHAs witnessed and could closely follow their neighbors' health concerns and daily issues. They knew whose child had undergone which vaccinations; when

a new bride moved into a household; who was pregnant; and what contraception methods people used, if any. As neighbors, however, they knew and did much more, and their perspective exceeded the relationalities foreseen by the program, and its bureaucratic imperatives. While generally ASHAs strongly believed in the truths of *samajh* as propagated by the health interventions, they had sympathies towards the neighbors who were reluctant to enroll in the program. Both Manju and Anita talked about why some women turned away from deliveries at the hospitals: frequently, traveling to a far-away hospital was impractical for those who had children and working husbands. At the hospitals, patients were often confronted with rude behavior from the doctors, inadequate attention from medical staff, and prescriptions requiring purchases of expensive medications from private pharmacies. For many women in Halpuri, seeking assistance from distant hospitals in the city of Delhi entailed more difficulties than giving birth at home, with assistance from *dais* (traditional birth attendants) or local unlicensed biomedical practitioners. ASHAs' concerns about the health of the neighbors and *samajh denā* were thus accompanied by considerations of the actual difficulties Halpuri residents faced in their everyday lives.

ASHAs' critiques of the program and their experiences with it reveal the paradoxes of their double roles as CHWs. Representing the governmental health program, they themselves were skeptical towards the state's attempts to intervene in women's reproductive health practices when they were burdensome. While some residents approached ASHAs themselves when they needed some assistance, *samajh denā* ran the risk of being seen as not caring enough, or undermining neighbors by criticizing their childbearing practices or by being inconsiderate about the difficulties that rose in their everyday lives.

The attempts to balance their work, bureaucratic imperatives, and neighborly commitments resulted in ASHAs changing their modes of work. They turned to the tasks that allowed them to complete their work, secure payment, and avoid confrontation with their

neighbors. Over my fieldwork, I witnessed little active *samajh denā* ASHA workers, even if they were directly facing situations and health behaviors that demanded a reform from the vantage point of the health program. Seeing her neighbor applying *kājal* (kohl) on her grandchild's eyes, for instance, Anita told me - an ethnographer - she had learned at the PHC that the practice is harmful for the child's eyes, but she did not try to interfere in the neighbor's undertaking that was meant to protect the baby from an evil eye. ASHAs also prioritized polio vaccination campaigns which were more public and generally demanded less persuasion of the neighbors, and limited their activities, such as motivations for sterilization operation, to assisting only those who requested it. Some ASHAs would only register their intervention at the PHC if a pregnant woman came there on her own initiative.

At times, these negotiations had an effect on the ways the program unfolded on the ground. One day, Anita and Manju worriedly discussed a case of a woman from Manju's area who had delivered a baby at home, and not at the hospital: should Manju tell her to go to the PHC to register the newborn, or no? "I will be penalized for a non-hospital delivery. If there are 5 deliveries, and 3 are at home, we get penalized for not motivating. Last year, this happened to Geeta." In the end, she decided to tell the woman to go to the PHC and at least receive the incentive for registering the newborn.

Anita took further steps in altering her work in order to accommodate it to relational commitments. At one point, she was thinking about quitting ASHA work because she was failing to "meet the targets" of sterilization operations and she was feeling pressurized at the PHC. Disgruntled by working with their neighbors and contending that she could not persuade more women to undergo sterilization operations (even though they were popular among most of the women in Halpuri), she got herself transferred to work in another neighborhood. While this ran against the formal rules of the ASHA program, the doctor of

the PHC allowed Anita to change her working area because the new one was in the vicinity of Halpuri. Meanwhile, Manju took over Anita's work at Halpuri.

Anita's new working area was a low-quality housing settlement built by residents of a richer neighborhood for leasing rooms to poor migrants from other states in India. Residents of this colony were of similar economic status to those residing in Halpuri, and some had relatives from Halpuri. Built in a more planned manner, it had an appeal for Anita because it had "straight lanes" (*sidhī galī*). She often talked of the area as inhabited by "nicer" people, who spoke politely, and invited her for tea when she visited their homes. Anita contrasted the area to Halpuri, and expressed her dislike of the *jhuggī* cluster where she herself lived. She complained to me about the complicated *galīs* of the Halpuri and how they made her work difficult, how neighbors shunned her attempts to "motivate" them, and were reserved in welcoming her to their homes.

Thus, Anita rejected her work in Halpuri precisely because she lived there. She felt ASHA work was easier among people with whom she did not share daily concerns, and with whom she could practice her work by cultivating pleasant yet more distant relationships. In her new working area, she was served tea - a sign of respectful hospitality towards a guest among the urban poor and generally in India, that I had myself experienced in Halpuri so many times. Careful relational balancing and detachment animated these moves. For some ASHAs, work itself provided possibilities to distance themselves from other residents (Author yyyy). Geeta was happy with her job, and that her mother-in-law and husband allowed her to work. She liked it a lot, since it kept her busy, and she did not have to spend days gossiping with her neighbors, as she put it.

While the program foresaw ASHAs' belonging to their communities as an asset, constituted by mutual interest in the program and attachments, for ASHAs in Halpuri, working in a neighborhood where they lived posed a conflict of commitments. What came to

the fore was the importance of the subtleties of relationships, their qualities, such as detachments and indeterminacy, rather than indiscriminate belonging. ASHAs' daily work of advancing the public healthcare protocols, propagated at the PHC was enveloped in the concerns about the potential outcomes of their tasks, wellbeing of their neighbors, and the injustices of the public healthcare system. ASHAs also negotiated their vulnerabilities amidst the stakes of poverty relational intensities and divides in their communities.

Given the program's participatory context, ASHAs were well-versed in voicing their critiques. Often, it was the bureaucratic necessities – paper assessments of their work - such as registering cases and achieving targets that stood in the way of ASHAs' sensibilities of care. Bureaucratic tasks here impeded care and undermined “local” knowledge, thus reproducing structural violence and exclusion (Gupta 2012, Kleinman et al. 1997). ASHAs' moral becoming through care for relationships aimed to resolve the contradictions posed by their role, demanding care for the communities through a public health work, and reasserted their status as carers.

ASHA WORK AND NEIGHBORLY DETACHMENTS

On one hot spring day, I was spending time with Anita in her *galī*, as usual. The sun was scorching and Anita's neighbors were seeking shelter from its relentless glare inside their *jhuggīs*. Anita, however, rarely rested or slept in the daytime. Her ASHA work and household responsibilities kept her busy all day, and she was about to do some ASHA work later on. Suddenly, our conversation was interrupted as Sanjana's one-year old grandchild fell on the ground as the chair, on which he had been placed, overbalanced. After the child's uncle picked her up and took her inside the house to his mother, Anita quietly exclaimed, “You see, the child fell. This child is weak [*kamzor*] [...] - she swings, and she does not keep her body and head straight.” Anita continued: “She [Ruby, Sanjana's daughter] did not take

any calcium and iron pills, neither did she take injections [during the pregnancy]. She keeps herself far away from the dispensary [PHC]. She goes on the road and talks to him [her lover].”

Anita’s condemnations were underpinned by what she saw as morally legitimate bodies of women and children, living up to the standards of the health program she represented. Ruby’s baby was “weak” because she delivered her at home (not in a hospital), did not enroll in the governmental reproductive health program, and did not take vaccinations and calcium pills from the PHC. Weakness here referred to the bodies of those who lacked *samajh*. Anita’s criticism was further upheld by Ruby’s supposed extramarital affair. She went on to talk of Ruby’s behavior: “She has a lover, and goes on the road to talk to him on the phone while her husband is working during the day. I can’t put up with one husband. How can she deal with two?!” Ruby’s explicit sexuality seemed to be further evidenced, for Anita, by the fact that Ruby was a mother of four children – double the number promoted by India’s family planning programs. Ruby’s mother, Sanjana, also had four children, more than the average in Halpuri. According to Anita, Ruby “kept herself away” from the PHC because she feared that AIDS and HIV testing could expose Ruby’s suspected extramarital affair.

A few months before the incident with the child falling of the chair, when on my way towards Anita’s home, the old lady Meena, Shalini’s mother, greeted me on Halpuri’s main road with the news: “A baby was born [*nayā baccā hai*].” Ruby had given birth to a baby girl, her fourth child. She had delivered her at home, with a *dāī* (traditional birth attendant) from a neighboring colony, whom they paid with 1100 Rupees (around 15 US dollars) and a sari, a considerable amount for a poor family in Delhi. Ruby did not breastfeed the baby on the first day and her younger sister cleaned her house, practices partly corresponding to births attended by *dāīs* in northern India (Pinto 2008). After the delivery, a private, unlicensed

biomedical health practitioner popular in Halpuri administered a tetanus injection to the newborn.

Neither Sanjana nor her daughter Ruby saw any need to go to a hospital for the delivery. The baby had received *sūī* (a needle) already, and “what was needed to be done, had been done,” Ruby said to me. A hospital delivery would require “too much *pareśānī* [worries],” Sanjana said. At the hospital, people are sent from one spot to another. A family member would need to leave home and take a day off from work in order to help the mother. A hospital is for those who are ill – but deliveries can be done at home. How can they make a delivery better at a hospital? Ruby also did not feel the need to visit the PHC for prenatal and postnatal check-ups.

These birth and postnatal care practices were problematic from the vantage point of the healthcare program and Anita. However, Anita’s reprehension was not raised solely because of her loyalties to the healthcare program, but rather because her relations with Ruby’s family were already fraught. Although Sanajana’s and Ruby’s *jhuggīs* were next to Anita’s, they kept apart. Silences and eschewals were common between the women. To avoid further conflict and confrontation, Anita did not interfere in her neighbor’s reproductive health matters or try to change her mind by practicing *samajh denā*. This form of detachment was enfolded in Anita’s knowledge of “whom to say what” (Lambek 2010) as she went about her daily life in Halpuri. Silence and concealment, as Das (2012) points out, also carry ethical meanings.

CONCRETE OTHERS: A CARING FRIEND

Anita’s ASHA work did not always come into conflict with her neighborly commitments, but rather was incorporated into her existing relations of care for neighbors who were also

friends. Relations with concrete others involved a different kind of intimacy, underscored by more explicit forms of care than detachment and suspension of her ASHA role. This became clear when Anita's neighbors - Shalini's family - had decided (unlike Ruby), that their newborn would be delivered at the hospital. Anita accompanied Shalini's son Raju and his wife to the hospital for the delivery. While talking to me, Raju, Shalini's son and baby's father, remembered an odd experience he had had there. He had been asked to donate blood, which he had thought would be used for his wife, but as he later found out, was not. Nevertheless, he was happy he had helped someone else, and felt grateful that his wife delivered the baby successfully at the hospital. This would not have been possible without Anita's help, he noted. A few weeks later, I went with Anita to the clinic to pick up a birth certificate for the newborn. The favors between families extended beyond the health work. Over my fieldwork I observed how the families maintained a good relationship on a daily basis and during celebrations. Anita's teenage daughter was also best friends with Shalini's daughter, and Anita's brother had helped Raju to get a job in a government-run alcohol shop through connections. Unlike Sanjana, who avoided talking about Anita and the clinic with me because of my friendship with Anita, Shalini openly expressed her fondness of a neighbor health worker: "She is very good. She helps us." Raju, too, saw Anita as a friend, whose care unfolded on numerous occasions over their time of living in the presence of each other, and not as a governmental health system representative. Likewise, Anita never spoke ill of Shalini's family.

Detachment as "care for relationships" (Neumark 2017) animated much of ASHAs' work, but it also enabled a differentiation of relations and commitments. Whereas some neighbors cultivate friendships, others remain just neighbors – thus drawing what Han (2014) refers to as the boundaries between a neighbor and a friend. Engaging in those boundaries, Han remarks, is a relational labor of making oneself available to the other. It is this care for

concrete others as an ethical labor and a mode of living with others, exceeding the governmental and biomedical logics of care, that marked the dimensions of ASHAs' daily lives. Rather than just care for relationships as a whole that sought to preserve the possibilities for neighbours to live next to each other, this form of care was about sustaining the good in the relations and friendship. For Anita, helping those with whom she had a good relationship and at the same time transferring to another neighborhood for work posed no contradiction, as she was a friend, a neighbor, and a health worker. This labor of care also stipulated the contingency and temporality of relationships – ASHAs' moral becoming through their work unfolded over the course of time, as it was absorbed into the vicissitudes of everyday life in Halpuri.

CONCLUSION

The absorption of ASHA work into the ethics of neighborly intimacy, caring relationships or detachments in Halpuri did not render the governmental health program irrelevant. *Samajh* – knowledge acquired through participation in the program and its stipulated governmental affiliation – came to be central to ASHAs' understanding of who they were and the work they were responsible for carrying out. Being CHWs, they dealt with the burdens and advantages of representing the state in an urban poor neighborhood. Anita confirmed this to me during a recent conversation with her, when I was revisiting Halpuri. Being an ASHA, she also had to deal with numerous questions from residents about other governmental schemes, the scope of which reached way beyond matters of health, and to which she often did not have answers. Association with the governmental program had an effect on ASHAs' neighborly relations – it allowed to establish a higher social status, gain respect and trust, or, by contrast, suspicion, resentment and mistrust (Author yyyy). ASHA work was thus underscored by a subtle balancing of manifold commitments and power relations.

Community health work is being increasingly emphasized as an effective strategy to tackle the shortage of access to public health across many developing countries (WHO 2019). Programs run by governments and NGOs alike mobilize individuals, mostly women, to conduct health work among their own communities, mustering the social ties that CHWs cultivate in their daily lives and recognizing them as an asset (Schuster 2015). The NHM rationale assumed ASHAs as community members whose care is enacted through motivation of their neighbors to change their health-related behaviors and increase community participation. While acknowledging the political identities, gender and caste and community inequalities, the NHM still rendered ASHAs' relationships to their neighbors as if they are underlined by mutual agreement and attachments and sought to constitute gendered caring roles. However, I have shown how care for concrete others, judgements and detachments play role in ASHA work, whose practice of care exceeds relationalities foreseen in the program. On the one hand, ASHAs incorporated their work in the existing relationships, including those that presupposed detachments, exclusions, and marginalization of already vulnerable or stigmatized groups or individuals in their communities, and those with whom their relationships were fraught or distant. On the other hand, their formal work was extended by their friendships and care for others. Mosse (2004) suggests such disjunctures between development policy, its ideological foundations and practice result from development actors' need to maintain relationships at various levels of development organization. ASHAs participated in developmental practice through cultivation of modes of intimacies and relationships that allowed and enabled the continuity of their practice and to balance the imperatives of everyday life. For anthropologists, then, the task is to go beyond the assumption that the relations of the CHW with her community as given, and to explore the kinds of relations in specific contexts, over the course of time, and the ways the

relationalities that cannot be contained or predefined by such programs are maintained and negotiated.

This task entails what Das (2012), calls an identification of the ethical in the ordinary: one should view the ordinary not as a realm of repetitive acts that characterize the machine-like operational mode, but rather seek to detect what is human in those acts. Seen this way, ASHA work in Halpuri was informed by ordinary ethics: rather than simply engaging in repetitive demagogue-like acts of *samajh denā*, they conducted their work by means of cultivating the regard of others: through care, affective ties, awareness of the others, judgements and detachments. These ethical sensibilities, embedded in the ordinary, are not only directed towards a common or normatively good, as Das (2012) points out, but can entail harm and violence as well, as seen in ASHAs' judgements and detachments. While such acts diverged from care for concrete others, and would be seen "wrong" from the perspective of the program, they were embedded in the ASHAs' relational moral striving in the neighborhood. A judgment about whether to "motivate" one's neighbors or not was a matter of negotiating what was dignified and acceptable to tell the other openly and what would be interpreted as an unwelcome judgment and interference into a neighbor's family matters (even while holding a disapproval of them); what was an act of help and care for a friend, and what was a self-interested act of completing ASHA task potentially escalating a conflict. Their work was incorporated into the larger labor of making their lives livable with others under already difficult conditions of poverty, and forging themselves as legitimate health workers.

NOTES

¹ All names of persons and places are pseudonyms.

² While I am aware of the often-made distinction by philosophers between the concepts "moral" and "ethical", I follow anthropologists, who use them interchangeably. See Fassin (2012) and Lambek (2010).

³ These incentives were far smaller than an average monthly salary. ASHAs have been mobilizing across India in order to acquire a worker, rather than activist, status, and be paid regular salaries. In Halpuri, they often expressed dissatisfaction with inadequate payments.

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